REGISTRATION FORM

PATIENT NAME: ____

ADDRESS (STREET, CITY, STATE, ZIP): ____

____

HOME PHONE: ____________ **WORK PHONE:** ____________ **CELL PHONE:** ____________

E-MAIL ADDRESS: ___________________ **OCCUPATION:** ___________________________

DATE OF BIRTH: _________/_________/__________ **AGE:** _________ **SEX:** ______________

SOCIAL SECURITY NUMBER: __________________ **MARITAL STATUS:** ________________

NAME OF SPOUSE/GUARDIAN/PARENT: ____

PRIMARY CARE PHYSICIAN – ADDRESS & TEL: ____________________________________

____

REFERRED BY: ____

PREFERRED PHARMACY- NAME, ADDRESS & TEL: ___________________________________

____

PRIMARY INSURANCE: ___________________ **INSURED NAME:** ______________________

POLICY NUMBER: _______________________ **GROUP NUMBER**: ____________________

INSURED SEX: ____ **DATE OF BIRTH:** ___/___/___ **SOCIAL SECURITY:** ____________

RELATIONSHIP TO PATIENT (SPOUSE/GUARDIAN/OTHER): ______________________

INSURED'S EMPLOYER: ____

SECONDARY INSURANCE: ________________ **INSURED NAME:** ______________________

POLICY NUMBER: _______________________ **GROUP NUMBER**: ____________________

INSURED SEX: ____ **DATE OF BIRTH:** ___/___/___ **SOCIAL SECURITY:** ____________

RELATIONSHIP TO PATIENT (SPOUSE/GUARDIAN/OTHER): ______________________

INSURED'S EMPLOYER: ____

SIGNATURE: ___________________________________ **DATE**: _______________

MEDICAL HISTORY

Date___________________

Patient Name: ____________________________________

Do you wear glasses? ________________

Do you wear contact lenses?____________

Check box if you have any of the following symptoms:

- ☐ Vision problems while driving, reading, or Watching TV
- ☐ Blurred or distorted vision
- ☐ Flashes of light
- ☐ Webs or spots in your vision
- ☐ Light sensitivity
- ☐ Double vision
- ☐ Eye pain
- ☐ Foreign body sensation
- ☐ Redness
- ☐ Tearing, itching, or burning
- ☐ Lumps or growths around the eyes
- ☐ Drooping eyelids
- ☐ Headache
- ☐ Discharge
- ☐ Other ________________________________

PERSONAL HISTORY

Have you ever been treated for any of the following medical conditions?

- ☐ Cataract
- ☐ Diabetes
- ☐ Diabetic Retinopathy
- ☐ Dry Eyes
- ☐ Eye Injury
- ☐ Lazy/Crossed Eye
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Asthma / Lung Disease
- ☐ Angina
- ☐ Arthritis
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Migraines
- ☐ Pneumonia
- ☐ Raynaud's Syndrome
- ☐ Sleep Apnea
- ☐ Thyroid Disease
- ☐ Other ________________

____

____

Do you take any eye medications? ☐ Yes ☐ No

If yes, please list: ____

____

Do you take any other medications or herbal supplements? ☐ Yes ☐ No

If yes, please list: ____

____

____

Do you have any drug allergies or allergies to eye drops? ☐ Yes ☐ No

If yes, please list: ____

____

Have you ever had any eye surgeries or laser treatments? ☐ Yes ☐ No

If yes, please list, including dates: ____

____

In the past ten years have you been hospitalized or had other surgery? ☐ Yes ☐No

If yes, please list, including dates: ____

____

____

Patient Name:_______________________________

FAMILY HISTORY

Do you have a family history of any of the following medical conditions? (If yes, who)

☐ Glaucoma ____________________________
☐ Cataracts ____________________________
☐ Macular Degeneration ____________________
☐ Arthritis ____________________________
☐ Cancer ____________________________
☐ Diabetes ____________________________
☐ Heart Disease _________________________
☐ Hypertension _________________________
☐ Migraines ____________________________
☐ Thyroid Disease _______________________

SOCIAL HISTORY

Do you or did you every smoke? ☐ Yes ☐ No (Never smoked)
If yes, how much?
☐ Current every day smoker
☐ Current some day smoker
☐ Former smoker
Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _______________________
Do you exercise regularly? ☐ Yes ☐ No

RACE AND ETHNICITY

What race do you consider yourself?
☐ American Indian
☐ Asian
☐ Black
☐ Native Hawaiian
☐ White
☐ Other ____________________________________

What ethnicity do you consider yourself?
☐ Hispanic
☐ Non-Hispanic Origin
☐ Other____________________________________

What is your primary language?
☐ English
☐ Other____________________________________

☐ I prefer not to disclose my race, ethnicity and/or primary language

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REVIEW OF SYSTEMS

Do you currently have any of the following problems?

Fatigue, unexpected weight loss/gain chronic fever ……………………………………	☐ Yes	☐ No
Ear/ nose/ throat problems (sinus, sore throat) ………………………………………	☐ Yes	☐ No
Respiratory problems (shortness of breath, wheezing) ………………………………	☐ Yes	☐ No
Heart problems (chest pains, irregular heart beat) …………………………………	☐ Yes	☐ No
Gastrointestinal problems (heartburn, abdominal pain) …………………………...	☐ Yes	☐ No
Urinary problems (pain, discomfort, blood in urine) ………………………………..	☐ Yes	☐ No
Musculoskeletal problems (joint pain, muscle aches) ………………………………..	☐ Yes	☐ No
Skin problems (excessive dryness, rashes) ……………………………………………...	☐ Yes	☐ No
Neurological problems (headaches, paralysis, numbness) …………………………	☐ Yes	☐ No
Psychiatric problems (depression, anxiety) ………………………………………………..	☐ Yes	☐ No

Patient Lifestyle Questionnaire

Thank you for taking a few minutes to complete this questionnaire. The information you provide will help us to better understand your vision care needs.

What is your professional environment? (Check all that apply)

☐ I work in a professional business office. ☐ My job requires travel (driving/flying/both).
☐ I work from home. ☐ I work outside most of the time.

How much time do you spend each day at a computer?

☐ 0-1 hour ☐ 1-2 hours ☐ 3-5 hours ☐ 5+ hours

How much time do you spend driving at night? (Hours/minutes) _________

What type of outdoor activities do you participate in? (*Check all that apply*)

☐ Boating ☐ Biking ☐ Golfing ☐ Gardening ☐ Hiking ☐ Skiing ☐ Team Sports

What are your indoor hobbies?

☐ Arts/Crafts ☐ Reading ☐ Scrapbooking ☐ Sewing ☐ Other ___________

Please list any skin allergies: ____

Are you concerned about protecting your eyes from harmful UV rays? ☐ Yes ☐ No

What do you currently use for sunwear? ____

What did you like about your last pair of glasses? ________________________________

What would you change? ____

What did you like about your last pair of sunglasses? ______________________________

What would you change? ____

Do you currently wear Progressive lenses, are you happy with them? ☐ Yes ☐ No

<u>Office Use Only</u>

Vision Care Recommendations:

Frames ________ **Lenses** ________ **Sunglasses** ________ **Contacts** ________ **Other** _________

EYE CARE ASSOCIATES & GLAUCOMA CONSULTANTS
MEDICATION HISTORY RELEASE

I hereby permit Eye Care Associates to download my medication history for the purpose of practicing medicine and treating me.

______________________________ ______________________________

Responsible Party's Name **Responsible Party's Signature**

____

Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)/MEDICAL RECORDS

I hereby give my consent for **Eye Care Associates/Glaucoma Consultants of Long Island** to use and disclose protected health information about me in order to carry out treatment, payment, and healthcare operations.

With this consent, **Eye Care Associates/Glaucoma Consultants** may call my home or other alternative location and leave a message on voice mail or in person, in reference to any items that assist the practice such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results.

With this consent, **Eye Care Ophthalmology/Glaucoma Consultants** may mail to my home or other alternative location any items that assist the practice, such as appointment reminders and patient statements.

______________________ __________________________________ ___________

Patient's Name **Signature of Patient or Legal Guardian** **Date**

BENEFITS RELEASE

<u>Authorization to release:</u>

I hereby authorize Drs. Prywes, Weinstein, Marcus, Rothman, Angelilli, Serle, Hayes and/or Auerbach to furnish my insurance company all information that the insurance company may request concerning my present claim.

<u>Assignment of Benefits:</u>

I hereby assign to the doctor all money to which I am entitled for expenses relative to the services performed from time to time, but not to exceed my indebtedness to the doctor. I understand that any monies received from my insurance company over and above my indebtedness will be refunded to me when my account is paid in full. I understand that I am financially responsible to the doctors for fees.

______________________________ ______________________________ ___________

Responsible Party's Name **Responsible Party's Signature** **Date**